		FOR OHF USE					

LL1

2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0037556

Facility Name: Columbia Convalescent Center

Address: 253 Bradington Dr. (Number) Columbia (City) 62236 (Zip Code)

County: Monroe

Telephone Number: 618 281-6800 **Fax #** 618-281-6557

IDPA ID Number: 37-1280633001

Date of Initial License for Current Owners: 12/19/91

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: David Read **Telephone Number:** 618-234-2273

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1-1-2001 to 12-31-2001 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) 3-20-2002 (Date)
(Type or Print Name) David Wendler
(Title) Administrator

Paid Preparer

(Signed) (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Columbia Convalescent Center # 0037556 Report Period Beginning: 1-1-2001 Ending: 12-31-2001

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 7-1-2000

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	119	Skilled (SNF)	119	43,435	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	119	TOTALS	119	43,435	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	741	1,825	2,299	4,865	8
9	SNF/PED					9
10	ICF	14,455	19,662		34,117	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	15,196	21,487	2,299	38,982	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.75%

D. How many bed-hold days during this year were paid by Public Aid?
196 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 12/31/91

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 12 and days of care provided 2,299

Medicare Intermediary Administar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2001 Fiscal Year: 12/31/2001

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Columbia Convalescent Center # 0037556 Report Period Beginning: 1-1-2001 Ending: 12-31-2001

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	189,184	13,524	9,771	212,479		212,479		212,479			1
2	Food Purchase		163,218		163,218		163,218	(4,010)	159,208			2
3	Housekeeping	139,411	11,162	1,543	152,116		152,116		152,116			3
4	Laundry	64,438	6,028	12,973	83,439		83,439		83,439			4
5	Heat and Other Utilities			140,510	140,510		140,510		140,510			5
6	Maintenance	58,120	10,826	17,776	86,722		86,722		86,722			6
7	Other (specify):*											7
8	**TOTAL General Services**	451,153	204,758	182,573	838,484		838,484	(4,010)	834,474			8
	B. Health Care and Programs											
9	Medical Director			9,000	9,000		9,000		9,000			9
10	Nursing and Medical Records	1,578,373	35,181	3,621	1,617,175	(17,828)	1,599,347		1,599,347			10
10a	Therapy	48,853		167,754	216,607	(50,774)	165,833		165,833			10a
11	Activities	68,978	8,724		77,702		77,702		77,702			11
12	Social Services	44,962	193	1,450	46,605		46,605		46,605			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,741,166	44,098	181,825	1,967,089	(68,602)	1,898,487		1,898,487			16
	C. General Administration											
17	Administrative	87,017		290,137	377,154		377,154		377,154			17
18	Directors Fees											18
19	Professional Services			24,951	24,951		24,951		24,951			19
20	Dues, Fees, Subscriptions & Promotions			28,370	28,370		28,370	(8,739)	19,631			20
21	Clerical & General Office Expenses	133,731	9,537	24,340	167,608		167,608	(1,752)	165,856			21
22	Employee Benefits & Payroll Taxes			337,408	337,408		337,408		337,408			22
23	Inservice Training & Education			2,014	2,014		2,014		2,014			23
24	Travel and Seminar			6,682	6,682		6,682		6,682			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			109,407	109,407		109,407		109,407			26
27	Other (specify):*			8,264	8,264		8,264	(8,264)				27
28	**TOTAL General Administration**	220,748	9,537	831,573	1,061,858		1,061,858	(18,755)	1,043,103			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,413,067	258,393	1,195,971	3,867,431	(68,602)	3,798,829	(22,765)	3,776,064			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Columbia Convalescent Center #0037556 Report Period Beginning: 1-1-2001 Ending: 12-31-2001

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			193,301	193,301		193,301	(3,484)	189,817			30
31	Amortization of Pre-Op. & Org.			2,760	2,760		2,760		2,760			31
32	Interest			251,058	251,058		251,058	(5,910)	245,148			32
33	Real Estate Taxes			82,130	82,130		82,130		82,130			33
34	Rent-Facility & Grounds			1,284	1,284		1,284		1,284			34
35	Rent-Equipment & Vehicles			2,504	2,504		2,504		2,504			35
36	Other (specify):*											36
37	**TOTAL Ownership**			533,037	533,037		533,037	(9,394)	523,643			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		45,958	4,730	50,688	68,602	119,290		119,290			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops			7,498	7,498		7,498		7,498			41
42	Provider Participation Fee			65,318	65,318		65,318		65,318			42
43	Other (specify):*			7,016	7,016		7,016		7,016			43
44	**TOTAL Special Cost Centers**		45,958	84,562	130,520	68,602	199,122		199,122			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,413,067	304,351	1,813,570	4,530,988		4,530,988	(32,159)	4,498,829			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Columbia Convalescent Center # 0037556 Report Period Beginning: 1-1-2001 Ending: 12-31-2001

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(4,010)	2		4
5	Telephone, TV & Radio in Resident Rooms	(5,246)	27		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(3,484)	30		9
10	Interest and Other Investment Income	(5,910)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(3,018)	27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(8,739)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule Misc Inc.	(1,752)	21		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (32,159)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (32,159)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39	PT/OT/ST Licensed	x		50,774	10a-3	39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule Supplies	x		17,828	10-2	45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$ 68,602		47

Columbia Convalescent Center

ID# 0037556

Report Period Beginning: 1-1-2001

Ending: 12-31-2001

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2	Miscellaneous Income	(1,752)	21	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(1,752)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Columbia Convalescent Center # 0037556 Report Period Beginning: 1-1-2001 Ending: 12-31-2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(4,010)	0	0	0	0	0	0	0	0	0	0	(4,010)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(4,010)	0	0	0	0	0	0	0	0	0	0	(4,010)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(8,739)	0	0	0	0	0	0	0	0	0	0	(8,739)	20
21	Clerical & General Office Expenses	(1,752)	0	0	0	0	0	0	0	0	0	0	(1,752)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(8,264)	0	0	0	0	0	0	0	0	0	0	(8,264)	27
28	**TOTAL General Administration**	(18,755)	0	0	0	0	0	0	0	0	0	0	(18,755)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(22,765)	0	0	0	0	0	0	0	0	0	0	(22,765)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Columbia Convalescent Center # 0037556 **Report Period Beginning:** 1-1-2001 **Ending:** 12-31-2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(3,484)	0	0	0	0	0	0	0	0	0	0	(3,484)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(5,910)	0	0	0	0	0	0	0	0	0	0	(5,910)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(9,394)	0	0	0	0	0	0	0	0	0	0	(9,394)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(32,159)	0	0	0	0	0	0	0	0	0	0	(32,159)	45

Facility Name & ID Number Columbia Convalescent Center # 0037556 Report Period Beginning: 1-1-2001 Ending: 12-31-2001

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Steve Wolf	50.00%	Eldercare of Alton/Calvin Johnson Care Center	Bellville/Alton	Eldercare/SAMAS	Belleville	Mgmt Co.
Michael Riley	16.00%	Collinsville Care Center	Collinsville	SAMAS	Belleville	Mgmt Co.
Minority Shareholders	34.00%					

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [X] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	Owners Compensation	$ 290,137	SAMAS PARTNERSHIP	0.00%	$ 290,137	$	1
2	V	17	Administator Bonus	7,000	SAMAS PARTNERSHIP	0.00%	7,000		2
3	V	21	Bank Charges	125	SAMAS PARTNERSHIP	0.00%	125		3
4	V	19	Accounting Fees	310	SAMAS PARTNERSHIP	0.00%	310		4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 297,572			$ 297,572	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Columbia Convalescent Center # 0037556 Report Period Beginning: 1-1-2001 Ending: 12-31-2001

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	Steve Wolf	President	Owner	50.00	A 169000	10	14.00	Owners Comp	$ 169,403	17-3	1
2	Michael Riley	Secretary	Owner	16.00	0	20	30.00	Owners Comp	76,384	17-3	2
3	Steven Brant	Treasurer	Minority Owner	4.00	B 59665	10	17.00	Owners Comp	44,350	17-3	3
4											4
5											5
6		A- Eldercare, Inc.									6
7											7
8		B- Four Fountains									8
9											9
10											10
11											11
12											12
13								TOTAL	$ 290,137		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Columbia Convalescent Center # 0037556 Report Period Beginning: 1-1-2001 Ending: 2-31-2001

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization N/A
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Columbia Convalescent Center # 0037556 Report Period Beginning: 1-1-2001 Ending: 12-31-2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Union Planters		X	Mortgage Original	$21,665.39	1/1/94	$ 2,740,484	$ 2,113,575	6/5/04	7.2500	$ 159,544	1
2	Union Planters		X	Mortgage New Addition	$7,518.65	2/6/98	925,720	862,980	1/6/04	7.5000	66,638	2
3	Union Planters		X	Mortgage New Addition	$2,618.34	3/6/00	300,000	277,734	12/6/03	8.2500	23,600	3
4												4
5												5
	Working Capital											
6				Vendors						Varies	1,276	6
7												7
8												8
9	TOTAL Facility Related				$31,802.38		$ 3,966,204	$ 3,254,289			$ 251,058	9
	B. Non-Facility Related*											
10				Interest Income							(5,910)	10
11				Interest Const Period Amort.		1995	48,579				2,760	11
12												12
13												13
14	TOTAL Non-Facility Related						$ 48,579	$			$ (3,150)	14
15	TOTALS (line 9+line14)						$ 4,014,783	$ 3,254,289			$ 247,908	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Columbia Convalescent Center # 0037556 **Report Period Beginning:** 1-1-2001 **Ending:** 12-31-2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2000 report.	$	78,006	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	80,068	2
3. Under or (over) accrual (line 2 minus line 1).	$	2,062	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)	$	80,068	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	82,130	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:

1996	46,536	8
1997	54,206	9
1998	65,350	10
1999	78,005	11
2000	80,068	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Columbia Convalescent Center COUNTY Monroe

FACILITY IDPH LICENSE NUMBER 0037556

CONTACT PERSON REGARDING THIS REPORT David Read

TELEPHONE 618-234-2273 FAX #: 618-234-7777

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	04-17-481-028-000	Lot 2 & Pt Lot 1 Bradington Pl	$ 21,183.54	$ Yes
2.	04-17-481-005-000	Part Lot 4 Sur 416	$ 623.42	$ Yes
3.	04-17-481-004-000	Part Lot 4 Sur 416	$ 58,260.98	$ Yes
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 80,067.94	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number Columbia Convalescent Center # 0037556 Report Period Beginning: 1-1-2001 Ending: 12-31-2001

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 32,079 B. General Construction Type: Exterior Brick Frame Concrete/Steel Number of Stories One

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Resident Care	189,566	1991	$ 249,469	1
2	Resident Care	21,364	1993	28,115	2
3	TOTALS	210,930		$ 277,584	3

Facility Name & ID Number Columbia Convalescent Center # 0037556 Report Period Beginning: 1-1-2001 Ending: 12-31-2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	99		1991	1991	$ 2,115,587	$ 52,890	40	$ 52,890	$ (0)	$ 533,307	4
5			1991	1991	48,503	3,234	40	1,213	(2,021)	12,240	5
6	10		1998	1998	1,170,228	29,256	40	29,256	(0)	99,958	6
7											7
8											8
	Improvement Type**										
9	Land Improvements			1991	147,905	7,395	20	7,395	0	74,566	9
10	Fixed Equipment			1991	24,679	1,645	18	1,371	(274)	14,060	10
11	Alarm System			1992	910	61	15	61	(0)	579	11
12	Water Softner			1992	8,625	575	12	719	144	6,685	12
13	Carpet			1993	1,430		12	119	119	1,012	13
14	Guttering			1994	899	43	8	112	70	840	14
15	Pavillion			1994	7,400	617	12	617	(0)	4,625	15
16	Misc Improvements			1995	2,165	309	10	217	(93)	1,407	16
17	Drainage System			1996	1,374	92	15	92	(0)	475	17
18	Cold Water Line			1996	6,803	174	39	174	0	986	18
19	A/C Compressor			1996	1,574	225	7	225	(0)	1,162	19
20	Carpet			1996	591	84	7	84	0	434	20
21	Hot Water Heater			1996	3,473	496	7	496	0	2,563	21
22	Heat Trace & Hot Water Pipes			1996	1,535	102	10	154	52	710	22
23	Furnace and Air conditioning renovation			1997	1,690	169	10	169		775	23
24	Day Room Carpet and Window Treatments			1997	7,658	932	10	766	(166)	3,705	24
25	Telephone/Voice Mail System			1997	14,738	2,948	10	1,474	(1,474)	6,879	25
26	Entry Area Carpeting			1997	1,080	154	10	108	(46)	483	26
27	UPS Battery Back-up System			1997	733	147	10	73	(74)	329	27
28	Door			1997	1,485	38	10	149	111	602	28
29	Fan			1997	1,083	28	10	108	80	437	29
30	Landscaping			1998	4,030	269	15	269	(0)	848	30
31	Landscaping			1998	7,429	495	15	495	0	1,691	31
32	Irrigation System			1998	12,990	866	15	866		2,959	32
33	Parking Lot			1998	15,912	1,061	15	1,061	(0)	3,625	33
34	Landscaping			1998	10,479	699	15	699	(0)	2,388	34
35	Sidewalks			1998	19,864	1,324	15	1,324	0	4,524	35
36	Draperies & Window Treatments			1998	18,417	3,683	5	3,683	0	12,588	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Columbia Convalescent Center # 0037556 Report Period Beginning: 1-1-2001 Ending: 12-31-2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Flooring & Carpeting	1998	$ 36,840	$ 3,684	10	$ 3,684	$	$ 12,423	37
38	Decorating Wallpapering & Painting	1998	49,156	9,773	5	9,831	58	33,152	38
39	Alarm Security System	1998	17,574	2,849	5-7y	2,849		8,805	39
40	Attic Ventilating Fans	1998	6,179	618	10	618	(0)	2,266	40
41	Storeroom Locks	1998	593	85	7	85	(0)	262	41
42	Telephone Equipment	1998	1,940	194	10	194		695	42
43	Light Fixtures	1998	4,291	429	10	429	0	1,466	43
44	Therapy Room Sink	1998	1,213	173	7	173	0	533	44
45	Signage	1998	116	12	10	12	(0)	41	45
46	Site Lighting	1998	5,684	812	7	812		2,774	46
47	Landscaping	1999	6,955	464	15	464	(0)	1,110	47
48	Water Heater Replacement	1999	35,258	3,526	10	3,526	(0)	8,936	48
49	Washer & Dryer	1999	4,600	460	10	460		958	49
50	Air Conditionner	1999	8,965	897	10	897	(1)	2,073	50
51	Room Renovations	1999	6,778	929	5-10y	929		2,504	51
52	Door Security System	1999	14,347	1,435	10	1,435	(0)	3,446	52
53	Landscaping	2000	1,987	132	15	132	0	179	53
54	Water Heater Replacement	2000	6,848	685	10	685	(0)	1,313	54
55	Carpeting	2000	1,579	158	10	158	(0)	237	55
56	Floor Tile	2001	1,546	142	10	155	13	155	56
57	Landscaping	2001	2,127	87	10	106	19	106	57
58	Evaporator Coil	2001	2,514	147	10	147	0	147	58
59	Vinal Trim Window	2001	6,459	108	10	108	0	108	59
60	Painting	2001	6,080	51	10	51	0	51	60
61	Telephone System	2001	1,631	27	10	27	(0)	27	61
62	Alert System	2001	6,443		10				62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 3,898,972	$ 137,887		$ 134,402	$ (3,484)	$ 881,209	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Columbia Convalescent Center # 0037556 Report Period Beginning: 1-1-2001 Ending: 12-31-2001

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 584,312	$ 53,387	$ 53,387	$	8-10yr	$ 406,718	71
72	Current Year Purchases	29,270	2,027	2,027		8-10yr	2,027	72
73	Fully Depreciated Assets	38,017					38,017	73
74								74
75	TOTALS	$ 651,599	$ 55,414	$ 55,414	$		$ 446,762	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Resident Care	1994 Ford Van	1993	$ 38,214	$	$	$		$ 38,214	76
77										77
78										78
79										79
80	TOTALS			$ 38,214	$	$	$		$ 38,214	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 4,866,369	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 193,301	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 189,816	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (3,484)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,366,185	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Columbia Convalescent Center # 0037556 Report Period Beginning: 1-1-2001 Ending: 12-31-2001

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: None

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. N/A
This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$
13.	/2003	$
14.	/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 2,504 Description: Office and Nursing Equipment
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18			N/A		18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Columbia Convalescent Center # 0037556 Report Period Beginning: 1-1-2001 Ending: 12-31-2001

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number Columbia Convalescent Center # 0037556 Report Period Beginning: 1-1-2001 Ending: 12-31-2001

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	$	457	$ 24,050	$	457	$ 24,050	1
2	Licensed Speech and Language Development Therapist		hrs		159	8,052		159	8,052	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs		336	18,672		336	18,672	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts				53,170		53,170	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	X-Ray/Ambulance/Laboratory					4,730			4,730	
	Other (specify): Supplies Sold						10,616		10,616	13
14	TOTAL			$	952	$ 55,504	$ 63,786	952	$ 119,290	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Columbia Convalescent Center **#** 0037556 **Report Period Beginning:** 1-1-2001 **Ending:** 12-31-2001

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12-31-2001 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 82,471	$	1
2	Cash-Patient Deposits	6,035		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	565,607		3
4	Supply Inventory (priced at Cost)	18,369		4
5	Short-Term Investments			5
6	Prepaid Insurance	63,875		6
7	Other Prepaid Expenses	95		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 736,452	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	277,584		13
14	Buildings, at Historical Cost	3,292,618		14
15	Leasehold Improvements, at Historical Cost	606,353		15
16	Equipment, at Historical Cost	689,811		16
17	Accumulated Depreciation (book methods)	(1,462,704)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	50,000		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(50,000)		20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Const Period Int- Net	31,191		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 3,434,853	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,171,305	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 94,895	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	6,035		28
29	Short-Term Notes Payable	145,907		29
30	Accrued Salaries Payable	95,053		30
31	Accrued Taxes Payable (excluding real estate taxes)	4,521		31
32	Accrued Real Estate Taxes(Sch.IX-B)	80,068		32
33	Accrued Interest Payable	20,758		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Owners Comp Accrual	26,572		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 473,809	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	3,108,382		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 3,108,382	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,582,191	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 589,114	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,171,305	$	48

***(See instructions.)**

Facility Name & ID Number Columbia Convalescent Center # 0037556 Report Period Beginning: 1-1-2001 Ending: 12-31-2001

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 486,532	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 486,532	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	562,582	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(460,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 102,582	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 589,114	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Columbia Convalescent Center # 0037556 Report Period Beginning: 1-1-2001 Ending: 12-31-2001

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,659,423	1
2	Discounts and Allowances for all Levels	(16,479)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,642,944	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	271,764	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 271,764	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	10,915	12
13	Barber and Beauty Care	4,812	13
14	Non-Patient Meals	4,010	14
15	Telephone, Television and Radio	4,780	15
16	Rental of Facility Space		16
17	Sale of Drugs	106,341	17
18	Sale of Supplies to Non-Patients	21,231	18
19	Laboratory	15,242	19
20	Radiology and X-Ray	670	20
21	Other Medical Services	1,295	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 169,296	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	5,910	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 5,910	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Donations	1,904	28
28a	Miscelaneous	1,752	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 3,656	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,093,570	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	838,484	31
32	Health Care	1,967,089	32
33	General Administration	1,061,858	33
	B. Capital Expense		
34	Ownership	533,037	34
	C. Ancillary Expense		
35	Special Cost Centers	65,202	35
36	Provider Participation Fee	65,318	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,530,988	40
41	**Income before Income Taxes (line 30 minus line 40)****	562,582	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 562,582	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? no If not, please attach a reconciliation. Tax return incomplete**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Columbia Convalescent Center # 0037556 Report Period Beginning: 1-1-2001 Ending: 12-31-2001

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,984	2,223	$ 73,939	$ 33.26	1
2	Assistant Director of Nursing	2,008	2,220	51,065	23.00	2
3	Registered Nurses	12,988	13,957	294,080	21.07	3
4	Licensed Practical Nurses	16,241	17,429	278,565	15.98	4
5	Nurse Aides & Orderlies	76,750	82,496	880,724	10.68	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,467	4,850	48,853	10.07	8
9	Activity Director	1,979	2,156	27,325	12.67	9
10	Activity Assistants	5,553	5,973	41,653	6.97	10
11	Social Service Workers	2,964	3,279	44,962	13.71	11
12	Dietician					12
13	Food Service Supervisor	2,000	2,211	26,187	11.84	13
14	Head Cook					14
15	Cook Helpers/Assistants	5,823	6,281	65,098	10.36	15
16	Dishwashers	10,922	11,774	97,899	8.31	16
17	Maintenance Workers	5,500	5,895	58,120	9.86	17
18	Housekeepers	11,097	11,901	139,411	11.71	18
19	Laundry	9,468	10,061	64,438	6.40	19
20	Administrator	1,996	2,187	87,017	39.79	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	3,720	4,084	65,996	16.16	23
24	Clerical	7,043	7,569	67,735	8.95	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	182,503	196,546	$ 2,413,067 *	$ 12.28	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	97	$ 4,849	1-3	35
36	Medical Director	120	9,000	9-3	36
37	Medical Records Consultant	36	833	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	29	720	10-3	39
40	Physical Therapy Consultant	1,205	62,927	10a-3	40
41	Occupational Therapy Consultant	1,000	50,893	10a-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	63	3,160	10a-3	43
44	Activity Consultant				44
45	Social Service Consultant	41	1,450	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	2,591	$ 133,832		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Columbia Convalescent Center # 0037556 Report Period Beginning: 1-1-2001 Ending: 12-31-2001

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Dave Wendler	Administrator	0.00%	$ 87,017
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 87,017

B. Administrative - Other

Description	Amount
Owners Compensation	$ 290,137
TOTAL (agree to Schedule V, line 17, col. 3)	$ 290,137
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Duane, Morris & Heckscher	Legal	$ 4,034
Wessels & Pautsch	Legal	480
Van Ostrand & Elvidge Kelly	Legal	495
Flynn & Guymon	Legal	1,088
Newman,Freyman,Klein	Legal	3,500
SAMAS	Legal	129
Blue & Co.	Accounting	4,463
SAMAS	Income Tax	75
J.W.Boyle	Accounting	10,687
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 24,951

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 67,109
Unemployment Compensation Insurance	21,917
FICA Taxes	177,593
Employee Health Insurance	55,932
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
401k	3,708
Scholorships	25
Employee Relations	11,124
TOTAL (agree to Schedule V, line 22, col.8)	$ 337,408

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 625
Advertising: Employee Recruitment	9,870
Health Care Worker Background Check	
(Indicate # of checks performed 56)	676
Public Relations& Advertising	8,739
Professional Licenses	1,298
IHCA Dues	5,914
Unemployment Cons	328
Dues	286
Publications	634
Less: Public Relations Expense	(8,739)
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 19,631

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Employee Milage Seminars	2,305
Fees for seminars for above milage	4,377
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 6,682

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Columbia Convalescent Center # 0037556 Report Period Beginning: 1-1-2001 Ending: 12-31-2001

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1	Not Applicable		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Columbia Convalescent Center **#** 0037556 **Report Period Beginning:** 1-1-2001 **Ending:** 12-31-2001

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IHCA $5914**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **7 yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **None** Line **N/A**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **65,318**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **None** Has any meal income been offset against related costs? **N/A** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **0%**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **N/A** If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.